SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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Authority: *IC 2-5-26*

MEETING MINUTES[1]

Meeting Date:	**August 8, 2005**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Gary Dillon; Sen. Billie Breaux; Sen. Vi Simpson; Rep. Timothy Brown; Rep. Mary Kay Budak; Rep. David Frizzell; Rep. Charlie Brown; Rep. William Crawford; Rep. Peggy Welch.**

Members Absent: **Sen. Robert Meeks; Sen. Rose Antich-Carr.**

Senator Patricia Miller, Chairperson, called the meeting to order at 10:10 a.m. and introduced the members of the Commission.

EDS Update

Dennis Vaughan, EDS, gave the Commission an update concerning the payment of Medicaid claims. Mr. Vaughan provided the Commission with the following Medicaid statistics for the current fiscal year as well as the two previous fiscal years: the amount of

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

dollars paid, the number of claims paid or denied, the number of providers enrolled, the number of providers participating, and the number of enrolled recipients. See Exhibit 1 for specific statistics. Mr. Vaughan informed the Commission that Hoosier Healthwise mandatory risk based managed care enrollment will be implemented across the state by November 1, 2005. Medicaid providers will now be able to review and update provider enrollment data online. The automatic administration of patient spenddown billing goes into effect October 1, 2005. The intent of the automation is to reduce paperwork in tracking the spenddown requirement. In response to a question concerning whether the recipient will now be dependent upon the provider submitting the claim, Mr. Vaughan stated that he would find out the answer and report back to the Commission.

The Commission also asked about whether using WebMD to submit claims was optional and how EDS determines the validity of a claim submitted in this manner. Mr. Vaughan responded that using WebMD is optional and that providers may instead submit claims on their own. When told that some providers were under the impression that using WebMD was mandatory and that these providers were not being reimbursed for all claims right away, Mr. Vaughan said that he would follow up on this matter. The Commission also requested that Mr. Vaughan provide information concerning the number of providers, physicians, and dentists that are participating in the program compared to last year by geographic location to determine whether there is sufficient coverage of these providers statewide.

Managed Care Reimbursement for Medicaid Emergency Services

Dr. Bernard Emkes, Medical Director of Saint Vincent Health, began by stating that he believes in the concept of managed care and that managed care can save money and improve health outcomes. Dr. Emkes told the Commission that federal law requires a hospital to see every individual who goes to an emergency room for care. Hospitals incur costs for these individuals, including performing a medical screening. However, managed care organizations in the state are denying many emergency services claims that the hospital submits. Some managed care organizations will not even reimburse the hospital for the medical screening. Dr. Emkes feels that this is unfair. Dr. Emkes stated that he has reviewed approximately 1600 denied emergency room claims and has appealed the denied claims twenty percent of the time. He has won on appeal seventy percent of the time. Dr. Emkes stated that some of the claims should not have been denied in the first place and that both the denial of the claims and the appeals process are inconsistent. Part of the problem is the interpretation of the prudent lay person standard. Dr. Emkes further stated that sometimes it is difficult for the hospital to make the proper notification to the managed care organizations on the weekend or when the hospital is really busy. Some managed care organizations are denying 100% of the claim for necessary services because of this failure to notify or obtain authorization instead of a smaller penalty which is what occurs in the commercial marketplace.

Dr. Emkes stated that patients lack the education and accountability for the proper use of emergency room services and patients need to be educated on this subject. St. Vincent requires patients to attest on a form that the patient believes the treatment being sought is an emergency. The form also asks the patient whether the patient was referred to the emergency room in the hope that this will help in getting the claim approved.

Dr. Emkes made five recommendations: (1) managed care organizations should have to pay the triage screening fees; (2) clarify the responsibility of referral and notification and the procedure to follow; (3) have consistency in the approval or denial of emergency room claims; (4) establish a different procedure for appeal, possibly having the appeal go through an independent third party; and (5) failure to notify or receive authorization should not be a 100% penalty. In response to a question concerning whether charging a Medicaid patient a co-pay for overutilizing the emergency room could help, Dr.

Emkes stated that this would be a possibility. See Exhibits 2 and 3 for more information on Dr. Emkes' testimony.

Dr. Chris Burke informed the Commission that he is an emergency room physician. Federal law requires the hospital to see any individual who comes to the emergency room and to screen the individual in the same manner regardless of the type of insurance the individual has. Dr. Burke testified that 70% of the emergency room claims he has submitted have been denied and he appeals all of them with only a 5% appeal success rate. The cost of appealing the claims is expensive. Dr. Burke stated that he would like a uniform process and fair payment for the services provided. Dr. Burke pointed out that the Hoosier Healthwise card does not state the provider or network to which the patient belongs, causing confusion for the patient regarding where to seek care. Also, prompt care settings do not accept Medicaid, so many Medicaid patients do not have anywhere else to turn for care late at night or on the weekends. Consistency among the managed care organizations in approving or denying claims is needed. See Exhibit 4 for a handout provided by Dr. Burke.

Dr. Anthony Pelezo, Director of Harmony Healthcare, stated that consistency by the managed care organizations in approving emergency services claims is needed. Some managed care organizations pay all screening fees, while others pay only some of the screening fees. Because the prudent lay person standard is so vague, interpretation of this standard varies. A copayment, however, may deter a person who needs emergency services from getting the care the person needs. Education of patients has not improved improper utilization of the emergency room. Dr. Pelezo stated that managed care organizations have a nurse on call twenty-four hours a day and that members are told that they should call the nurse before going to the emergency room except for in a true emergency. However, there is almost no compliance with this requirement.

Secretary Mitch Roob, Office of the Secretary of Family and Social Services, stated that at his previous job at a hospital, charging a copayment brought concerns by the nurses that they would be robbed. He added that perhaps the copayment could be collected in another manner and said he would look into alternative means of collection. Secretary Roob further stated that because risk-based managed care will be statewide as of this November, FSSA will be reviewing the current structure of the program to determine whether changes are necessary. The current system of having three regions for the state may be changed by dividing the state into medical marketplaces of about seven or eight areas to better manage the program. The different Medicaid categories of eligibility and the different economic conditions of Medicaid recipients must be considered in any changes that are made.

Secretary Roob testified that he agreed that the Hoosier Healthwise cards should state the patient's network and that identification may be required in order to eliminate individuals using another person's card to obtain services. Secretary Roob stated that he believes that the reimbursement of emergency room services is primarily an Indianapolis issue. In response to a question from the Commission concerning whether a third party appeals process could be implemented and increase consistency among the managed care organizations, Secretary Roob stated that he was not sure what the current contracts addressed on this issue but it could be considered as a future change.

Emergency Rulemaking Update

Ms. Jeanne Labrecque, Director of Office of Medicaid Policy and Planning (OMPP), discussed three emergency rules: (1) the pharmacy reimbursement rule; (2) nursing facility changes as a result of the quality assessment fee; and (3) the increase in the premiums for the Children's Health Insurance Program (CHIP)[2]. Ms. Labrecque stated

[2] After the meeting adjourned, FSSA clarified that the increase in premiums for the CHIP program is following the regular rulemaking process and is not an emergency rule.

that FSSA has been working with the pharmacists to achieve savings in ways other than by cutting the pharmacy reimbursement rate. However, FSSA currently plans to publish the rule in the September Indiana Register leaving the reimbursement dispensing fee at $4.90 with the same dispensing fee for generics. Payment for insulin would occur as a prescription rather than covering insulin as an over the counter drug. The rule will also set the ingredients cost for brand name drugs as average wholesale price (AWP) minus 19% (instead of 13.5%). In response to questions from the Commission concerning why reimbursement includes a dispensing fee and why AWP is used, Secretary Roob responded that FSSA is increasing negotiations with pharmaceutical companies to get additional rebates. The Commission requested information concerning the cost of the drug in relation to the dispensing fee.

The rates for the nursing facilities are going to be changed in order to implement the nursing facility quality assessment fee. FSSA is negotiating how the process is going to work. Ms. Labreque stated that the increase in premiums under the CHIP program is an attempt to prevent cutting eligibility for the program. The premium will be based on a sliding fee scale and the federal government does not allow an increase of premiums of more than five percent.

Medicaid Reimbursement of Viagra

Ms. Labrecque stated that Indiana is one of the only state Medicaid programs that has not provided Viagra to sex offenders because of Indiana's medically necessary and prior authorization requirements. Indiana's Medicaid program only reimburses for Viagra if the drug goes through the prior authorization process and only if the drug is medically necessary to treat pulmonary hypertension. Medicaid has reimbursed for 45 erectile dysfunction prescriptions for 12 individuals. Nine of these individuals are less than eight years old.

Medicare Prescription Drug Benefit and Dual Eligibles

John Steele, Eli Lilly and Co., stated that dual eligibles are individuals who participate in both the Medicaid and the Medicare program. Currently, these individuals obtain prescription drugs through the Medicaid program. Beginning in January, 2006, these individuals will obtain their prescription drugs through the Medicare program. This change raises a couple of concerns for the consumer. First, the consumer will have to know that the consumer should be reviewing the different plans to determine the best plan for the individual by deciding which prescription drug plan covers the prescription drugs the individual currently takes. If the consumer who is a dual eligible does not choose a plan, the individual will be automatically assigned to a plan. Second, unlike the Medicaid program, the Medicare prescription drug program may charge copayments for each drug. This could cause a substantial financial burden for the individual.

Open enrollment for the Medicare prescription drug benefit begins November 15, 2005. The federal government has stated that the region Indiana is in will be offered at least two to five different plan choices. Indiana will be sending letters to the dual eligible individuals informing them of the upcoming deadlines. Indiana is also contacting institutions, providers, and other caregivers to ensure that people are aware of the deadlines for signing up for a plan. See Exhibit 5 for information provided to the Commission by Eli Lilly.

Sen. Miller stated that the next Commission meeting would be September 7, 2005 at 1:00 p.m. The meeting was adjourned at 12:30 p.m.